Supreme Court, U.S.
FILED
NOV 12 1992
OFFICE OF THE CLERK

No. 92-629

IN THE
Supreme Court of the United States
OCTOBER TERM, 1992

GRAYCE AUL, Individually, AUL PIPE & TUBING, INC., as a Fiduciary of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan, and HENRY AUL, as an Administrator of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan,
Petitioners,
vs.
ALLSTATE LIFE INSURANCE COMPANY, and OLD KENT BANK, as Trustee of the First Insurance Trust,
Respondents.

PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court review the question whether, where an ERISA welfare benefit plan expressly limits medical expense benefits to those expenses incurred while the group insurance policy which funds the plan is in force, and where Congress has expressly limited the requirement of "vested" benefits to pension plans, plan participants have a "vested" right to "lifetime" benefits for expenses incurred subsequent to the termination of the policy and the expiration of any extend benefit period?

2. Should this Court review the question whether, as a matter of federal common law, ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*, where the plan at issue is not ambiguous?

3. Should this Court review the question whether state decisional law of interpretation of insurance policies is "saved" from ERISA preemption pursuant to ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A), as a "law of any State which regulates insurance," where the decision at issue not only does not reflect the law of the state in which it was decided, but is limited to interpretation of the specific insurance policy at issue in that case?

RULE 29.1 LISTING

1. Parents

Respondent Allstate Life Insurance Company is a subsidiary of Sears, Roebuck & Co. and of Allstate Insurance Company.

Respondent Old Kent Bank is a subsidiary of Old Kent Financial Corporation.

2. Subsidiaries

Allstate Insurance Company of Canada and Allstate Life Insurance Company of Canada are subsidiaries of Respondent Allstate Life Insurance Company.

Respondent Old Kent Bank has no subsidiaries.

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No. 92-629

In The
SUPREME COURT OF THE UNITED STATES
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GRAYCE AUL, Individually, AUL PIPE & TUBING, INC., as a Fiduciary of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan, and HENRY AUL, as an Administrator of the Aul Pipe & Tubing, Inc. Employee Welfare Benefit Plan,
Petitioners,
vs.
ALLSTATE LIFE INSURANCE COMPANY, and OLD KENT BANK, as Trustee of the First Insurance Trust,
Respondents.

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondents, Allstate Life Insurance Company ("Allstate") and Old Kent Bank, respectfully request that this Court deny the Petition for Writ of Certiorari seeking review of the Ninth Circuit's decision in this case. The decision is unpublished.

STATEMENT OF THE CASE

A. Nature Of The Case

Petitioners commenced this action as a purported class action claiming that Petitioner Grayce Aul, as representative of the purported class, and the purported class members are entitled to benefits under the group insurance policy at issue for medical expenses incurred by them *after* the termination of the policy by Allstate.

Petitioners were participants in employee welfare benefit plans funded by Allstate's policy which was issued to a multiple employer trust, the First Insurance Trust, to which their employers subscribed. Allstate terminated the policy upon written notice, as provided by the terms of the policy. Although the policy expressly provides that benefits are paid only for medical expenses incurred by an individual while the policy is in force, Petitioners claim that they have a "vested" right to receive benefits for medical expenses incurred by them after the termination of the policy for sickness or illness sustained by them prior to termination.

Allstate rejected these claims based on the express terms of the policy and applicable law.

B. Statement Of Facts

1. Petitioners' Coverage Under The Group Policy

In or about April 1981, Aul Pipe & Tubing, Inc. ("Aul Pipe") made application to participate in the First Insurance Trust to provide group medical expense benefits to its employees and their eligible dependents under

Allstate's Group Policy No. 64003477 (the "Group Policy") issued to the First Insurance Trust. Aul Pipe's application was approved and coverage under the Group Policy became effective for certain Aul Pipe employees and their dependents effective May 1, 1981. [CR 69, pp. 40-41, ¶¶ 3, 5, 6; CR 49, pp. 5-6, ¶ 13.]

Petitioner Henry Aul, Aul Pipe's president, enrolled for employee coverage and dependent coverage, including coverage for his spouse, Petitioner Grayce Aul. [CR 69, p. 41, ¶ 6; CR 49, p. 3, ¶¶ 5-6.] Thereafter, Grayce Aul began receiving treatment for a liver condition and made claims under the Group Policy for expenses in connection with such treatment, and those claims were paid. [CR 49, pp. 8-9, ¶ 18.]

On or about February 17, 1989, Allstate mailed a notice to Aul Pipe advising it that coverage under the Group Policy would terminate on May 1, 1989 at 12:01 a.m. [CR 49, pp. 9-10, ¶ 21.] Effective May 1, 1989, Allstate terminated the Group Policy and terminated coverage thereunder for all employees of all employers participating in the First Insurance Trust. [CR 69, p. 41, ¶ 7; CR 49, pp. 9-10, ¶ 21.]

2. The Group Policy Expressly Provides That Allstate May Terminate The Group Policy Upon Written Notice.

The Group Policy expressly provides that it may be terminated by Allstate on written notice under the section "Termination of the Group Policy or the Employer's Plan":

> "We may end the group policy on any premium due date after the first policy anniversary. To do this, we must give at least 60 days written notice to the Policyholder." [CR 69, p. 76.]

In addition, Allstate must give written notice to the employer:

> "If we end the Employer's Plan, we must give written notice at least 31 days in advance." [*Id.*]

3. The Group Policy Expressly Limits Benefits Payable To Those Expenses Incurred By An Insured While Coverage Is In Force.

Petitioners' claim to "vested" benefits for medical expenses incurred after termination of the Group Policy presumably derives from, among other things, the Group Policy's "maximum benefit." [Petition, pp. 7, 11-17.]

The Group Policy's Schedule of Benefits provides as follows:

> "MEDICAL MAXIMUM: $1,000,000 DURING AN INSURED'S LIFE-TIME." [CR 69, p. 78.]

The Schedule is further explained under the heading "Comprehensive Medical Insurance" as follows:

> "MAXIMUM BENEFIT
>
> * * *
>
> **"Medical Maximum**
>
> "The Medical Benefits for each insured person may not exceed the

> Medical Maximum shown in the Schedule of Benefits." [CR 69, p. 56.]

Thus, the Group Policy provides that a maximum amount of $1,000,000 in benefits may be paid to an individual. Benefits are only paid, however, for expenses incurred while the Group Policy is in force and effect.

The Group Policy expressly limits the medical expense benefits available to "Eligible Expenses" incurred *while an individual is insured*:

> "**MEDICAL BENEFIT**
>
> "The Medical Benefit is paid for eligible Expense incurred for an injury or sickness *while insured* . . . In no event may the Medical Benefit exceed the proper maximum shown in the Schedule of Benefits." [CR 69, p. 55 (emphasis added).]

"Eligible Expense" is defined as meaning "the following types of Expense *incurred* for an Injury or Sickness while insured . . ." [CR 69, p. 56 (emphasis added).]

Further, the Group Policy defines "Expense" to mean:

> "a charge a person is legally obligated to pay. 'Expense' is deemed to be *incurred on the date the service or supply is furnished.*" [CR 69, pp. 65 (emphasis added).]

Finally, the Group Policy defines when coverage terminates as follows:

"**TERMINATION OF INSURANCE**

EMPLOYEES' INSURANCE

Subject to the Continuance of Insurance provision, your insurance ends when the first of these events takes place:

- the date the group policy or the Employer's Plan ends . .
  The end of insurance will not affect any claim for a loss that took place while the insurance was in force . . . ."

A similar provision applies to dependents' insurance. [CR 69, pp. 47-48.]

Thus, the Group Policy provides benefits only for expenses incurred while coverage is in force; it does not provide benefits for expenses incurred after termination of coverage unless, as indicated below, the individual is entitled to extended or continued benefits.

4. The Group Policy Provides Extended Benefits Or Continued Benefits To Individuals In Certain Circumstances When Their Coverage Terminates.

The Group Policy provides additional, limited benefits to persons in certain circumstances when their coverage would otherwise terminate.

In the case of the termination of the Group Policy, a three month extension of benefits is provided when a person is hospital confined:

"**EXTENSION OF BENEFIT**

We will pay the medical benefit after a person's insurance ends if:

- insurance ends because the Employer's Plan ends;
- the person is confined in a Hospital on the day the insurance ends;
- the person stays confined until the expense is incurred;
- the Expense is directly related to the confinement;
- the Expense is incurred within three months after the day insurance ends; and
- the person has not become covered by another group plan offering essentially the same coverage for the confinement." [CR 69, pp. 74-75.]

Further, the Group Policy also provides that insurance may be continued after termination if an employee is totally disabled, on leave of absence or on temporary layoff, for a period of no longer than three months:

"**CONTINUANCE OF INSURANCE**

If you go on an approved leave of absence or temporary layoff, or are Totally Disabled, your Medical Expense Insurance may continue until the first of these events take place:

- the date the group policy or the Employer's plan ends;

- the date the group policy or the Employer's Plan is changed to end insurance for the class to which you belong;
- the date the Employer stops paying the premium for your insurance;
- the date the leave or layoff or Total Disability ends; or
- the date the leave or layoff or Total Disability has lasted three months." [CR 69, p. 58.]

Finally, regardless of whether coverage is extended or continued, the Group Policy provides a medical conversion privilege under which an insured whose coverage terminates because the Group Policy ends may elect to purchase an individual policy from Allstate without proof of insurability. [CR 69, pp. 62-63.]

C. The District Court's Decision

Based on the express terms of the policy, the District Court held that the Group Policy expressly limits benefits to expenses incurred while the policy is in effect and that Petitioners do not have a right to "vested" benefits. It therefore granted Allstate and Old Kent Bank's motion for summary judgment. [CR 80.]

In ruling in favor of Respondents, the District Court rejected "any reading of [ERISA] requiring that welfare plans vest. To [do] so would subvert the desire of Congress not to incorporate the vesting requirements for welfare plans." [CR 80, p. 6, ¶ 13.] The District Court also rejected Petitioners' contention that a vesting requirement should be adopted as federal common law. [CR 80, pp. 10-14.]

Finally, turning to the proper construction of the Group Policy, the District Court held that "there is nothing in these provisions to give rise to any ambiguity or suggestion that rights to coverage vest under the comprehensive medical coverage of the policy. The conclusion is buttressed by review of the whole policy." [CR 80, p. 20, ¶ 41.]

D. The Ninth Circuit's Decision

The Ninth Circuit, in an unpublished Memorandum Decision filed January 22, 1992, affirmed the District Court's decision.

In doing so, the Court, applying the normal rules of contract construction, interpreted the Group Policy as a whole and found that it "unambiguously precludes the vesting of benefits . . ." [Petition, Appendix B, p. 10.]

By order filed July 15, 1992, the Ninth Circuit denied Petitioner's petition for rehearing and rejected the suggestion for rehearing en banc. [Petition, Appendix A.]

REASONS WHY THE PETITION SHOULD BE DENIED

The Petition for Writ of Certiorari should be denied.

In the first question, Petitioners urge this Court to ignore the plain wording of the contract and do that which Congress has refused to do, *i.e.*, adopt a rule requiring "vesting" for employee welfare benefit plans. This case does not properly raise that question, however. Rather, as both the District Court and the Ninth Circuit recognized, the plan language at issue is very detailed, specific and unique and unambiguously precludes vesting. This Court should not review a question which

turns on the alleged ambiguity of a plan which in fact is not ambiguous.

Similarly, the second question also is not properly raised by this case. The rule of *contra proferentem* that Petitioners urge the Court to establish, construes insurance policies such that ambiguities are construed against the insurance company. Again, since the policy at issue simply is not ambiguous, the Court need not reach this issue.

Finally, the state court rule which Petitioners claim is "saved" from ERISA preemption as California state decisional law regulating insurance, not only does not regulate the "business of insurance" within the test adopted by this Court, but does not even represent California law on the proposition for which Petitioners advance the decision. Thus, the Court should not review the third question.

Accordingly, this case turns on the specific wording of a number of very detailed, specific and unique provisions in the insurance policy at issue. The inquiry is highly fact specific. Although the questions presented by the Petition are important to the parties, there is no public importance associated with their outcome and the questions are not of sufficient importance to warrant review by this Court.

I.

THE FIRST QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The first question presented by the Petition is whether where the Group Policy expressly limits medical expense benefits to those expenses incurred while the policy is in force, and where Congress has expressly required "vested" benefits only for pension plans, this Court should rewrite the Group Policy, override Congress' legislation in this area, and establish federal law requiring the "vesting" of benefits under welfare benefit plans. In essence, Petitioners would have the Court find ambiguity where none exists and rewrite ERISA in a manner in which Congress has refused.

A. Petitioners Are Not Entitled To "Vested" Benefits Under The Terms Of The Group Policy.

Petitioners base their claim to "vested" benefits on a reading of isolated phrases in the Group Policy. An analysis of the *entire* policy, however, reveals that Petitioners' claims are misplaced and that the Group Policy does not provide the "vested" benefits they seek.

Under the express terms of the Group Policy, an individual is entitled to medical benefits only for expenses incurred while the policy is in force. In particular, the Group Policy provides:

> "The Medical Benefit is paid for Eligible Expense incurred for an Injury or Sickness *while insured.*" (Emphasis added.)

The clear intent of this language was to provide coverage only with respect to expenses incurred while the policy was in force. That intent was further clarified by the provision of the Group Policy stating that an individual's insurance ends on the date of termination of the policy:

> "Your insurance terminates . . . the date the Group Policy ends."

The phrasing of the Group Policy not only provides for benefits for covered medical expense charges incurred by an insured individual "while insured," but it also extends coverage beyond termination only for a limited time period, and only in limited circumstances, under the Extension of Benefits and Continuance of Insurance provisions.

When the Group Policy is read as a whole, it provides only for limited post-termination benefits, not the unlimited, lifetime coverage Petitioners seek. If Petitioners' claim that they are entitled, after termination of Group Policy coverage, to benefits for expenses incurred after termination, is correct, it would render the Extension of Benefits and Continuance of Insurance provisions meaningless.

Thus, the Group Policy provides for specific, limited post-termination benefits; it does *not* provide for the type of unlimited, lifetime coverage sought by Petitioners.

In the face of this clear language, Petitioners contend that three phrases in the Group Policy, when viewed in isolation, provide them with a right to "vested" benefits.

First, Petitioners claim that they have a right to unlimited, "lifetime" benefits for expenses incurred by them even after policy termination due to policy language providing a maximum benefit. [Petition, pp. 7,

11-17.] The policy must be read as a whole, however. As the other policy provisions, discussed above, make clear, the "maximum benefit" refers to the *amount* of benefit, not the *time period* during which benefits will be paid. If this were not the case, the language in the Group Policy limiting benefits to expenses incurred while the policy is in force, and providing extended and continued benefits after the policy terminates, would be superfluous.

The second phrase upon which Petitioners rely provides that "The medical benefit is paid for Eligible Expense incurred for an Injury or Sickness while insured." According to Petitioners, the provision must be read such that the policy pays benefits for expenses incurred after the termination of the policy for an injury or illness that occurred while the Policy was in force. [Petition, pp. 8-9, 21-24.]

This argument not only ignores the rest of the policy but completely misconstrues the plain meaning of this language. Nowhere is there any language, as Petitioners in effect would insert, which states that benefits are payable for an injury or sickness that arose while the insured was covered by the policy regardless of when the expenses are incurred. Instead, the plain language of the provision expressly limits benefits to (1) expenses incurred, (2) for an injury or sickness, (3) while insured. In other words, expenses must be incurred for an injury or sickness, *as defined by the policy*, while insured. As the District Court noted, "[t]he definitions of 'injury' and 'sickness' do not speak of the time they were incurred; only medical expenses are incurred at a given time." [CR 80, p. 19, ¶ 38.] Indeed, even under Petitioners' reading of the provision, expenses would be paid only for injury or sickness *while insured*. Here, the post-termination benefits sought are to cover medical

expenses for injury or sickness to Petitioners while they are *not* insured.

The third phrase upon which Petitioners rely is "The end of insurance will not affect any claim made for a loss that took place while the insurance was in force." According to Petitioners, this provision means that termination of the policy will not affect claims for eligible expenses incurred after the termination of the policy for injury or sickness that occurred while the policy was in force. [Petition, pp. 8-9, 21-24.]

To reach this result, however, Petitioners totally ignore those portions of the Group Policy limiting benefits to expenses incurred while the policy is in effect and limiting benefits available post-termination to continued and extended benefits. Indeed, it is submitted that even when viewed in isolation the provision at issue does not give rise to "vested" benefits. Instead, by its plain terms, the provision merely states that the termination of coverage will not affect *claims* for expenses incurred prior to policy termination. This reading is reinforced by the fact that the provision is found in the general, "Insuring Provisions" section of the policy, which applies to life and accidental death insurance benefits as well as to medical expense insurance benefits. In this regard the provision operates, for example, to provide that accidental death benefits will be paid if the specific loss in question, *i.e.*, death or loss of limb or an eye, occurs within 90 days of an accident. [CR 69, p. 53.]

The District Court correctly rejected Petitioners' claim on this score, noting that:

> ". . . read in context with the express limitations in the contract, that reading is improbable. The clause means that, notwithstanding the termination of insurance, you can still file claims

> for insurable expenses that occurred before termination, even if you file the claim after termination. Thus: the end of insurance will not affect any *claim* made for a loss that took place while the insurance was in force. This interpretation of the language is one that naturally flows from the words. Furthermore, it avoids plaintiff's reading, which would subvert the remainder of the limitations expressly stated in the policy." [CR 80, p. 18, ¶ 35 (emphasis in the original).]

The Ninth Circuit agreed, finding that the Group Policy "unambiguously precludes the vesting of benefits." [Petition, Appendix B.]

B. ERISA Does Not Require The "Vesting" Of Welfare Benefits.

ERISA specifically draws a distinction between "employee *pension* benefit plans" (which provide pension benefits which, by definition, vest for future availability) and "employee *welfare* benefit plans" (which provide, among other things, medical expense benefits during the period coverage exists). *Compare* 29 U.S.C. § 1002(1) *with* § 1002(2)(a). Congress included both pension and welfare plans in ERISA's reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, and standards of fiduciary conduct governing plan administration, 29 U.S.C. §§ 1101-4. ERISA, moreover, assures the protection of vested *pension* benefits by prescribing participation requirements, funding requirements, and vesting and accrual schedules, 29 U.S.C. §§ 1051-61, 1081-86, and by providing that an

employee's right to his or her normal retirement benefit shall be "nonforfeitable," 29 U.S.C. § 1053(a). Congress, however, expressly *excluded* welfare plans from ERISA's participation and vesting and funding requirements. 29 U.S.C. §§ 1051(1), 1081(a).

As this Court stated in *Massachusetts v. Morash*, 490 U.S. 107, 119 (1989):

> ". . . ERISA's vesting and funding requirements do not apply to welfare benefit plans . . . "

Similarly, in *West v. Greyhound Corp.*, 813 F.2d 951, 954 (9th Cir. 1987), the Court held that:

> "ERISA . . . expressly exempts employee welfare benefit plans from the sections concerned with vesting and accrual. 29 U.S.C. § 1051(1). While ERISA, in 29 U.S.C. § 1322, also guarantees the payment of all nonforfeitable benefits, this protection is applicable only to pension, stock bonus or profit-sharing plans. 29 U.S.C. § 1321(a); 26 U.S.C. § 401(a). *There is no language in ERISA which provides for the accrual of welfare benefits or guarantees that such benefits are vested or nonforfeitable.*" (Emphasis added.)

Numerous other courts have agreed that ERISA does not require the "vesting" of benefits under welfare benefit plans. *See, e.g., Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 491 (2nd Cir. 1988); *Turner v. Local No. 302, International Brotherhood of Teamsters, etc.*, 604 F.2d 1219, 1225 n.5 (9th Cir. 1979); *Coleman v. General Elec. Co.*, 643 F.Supp. 1229 (E.D. Tenn. 1986), *aff'd*,

822 F.2d 59 (6th Cir. 1987); *Hebert v. Red Simpson, Inc.*, 544 So.2d 751, 753 (La.App. 1989).

Accordingly, since ERISA does not require the "vesting" of medical expense benefits, "vesting" should not be read into a plan, as Petitioners attempt to do here, unless the plan explicitly and unambiguously so provides. The Aul Pipe Plan simply does not provide for the vested benefits Petitioners seek.

II.

THE SECOND QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The second question presented by the Petition is whether as a matter of federal common law ambiguities in an ERISA plan are to be construed under the rule of *contra proferentem*.

This question is not of sufficient importance to warrant review by this Court under Supreme Court Rule 10.1(c). Rather, this case does not properly present this question because, as noted above, there is no ambiguity in the plan at issue.

As shown below, Petitioners confuse the difference between rules of interpretation, which seek the parties' intent, and contract rules of construction, which are applied only if the intent cannot be determined. Under the law of trusts, which is incorporated in ERISA, the plan documents must be read by the plan administrator not under the contract doctrine of *contra proferentem*, but in light of all the circumstances, including the settlor's intent. *Firestone Tire & Rubber Co. v. Bruch*, 489

U.S. 101, 109 (1989); *Restatement (Second) of Trusts*, § 164.

It is submitted that terms in ERISA insurance policies, just like terms in non-ERISA insurance policies, are to be interpreted in light of the settlor's intent and "in an ordinary and popular sense as would a [person] of average intelligence . . . . We will 'not artificially create ambiguity where none exists.'. . . 'If a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy.' " *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990) (citations omitted), quoting *Allstate Insurance Co. v. Ellison*, 757 F.2d 1042, 1044 (9th Cir. 1985).

Contra proferentem is not aplied under contract law except as a constructional tool of last resort when the parties' intent cannot be determined. *Taylor v. Continental Group*, 933 F.2d 1227, 1233-34 (3rd Cir. 1991); *Record Club of America, Inc. v. United Artists Records, Inc.*, 890 F.2d 1264, 1271 (2nd Cir. 1989); *see also, Lippo v. Mobil Oil Corp.*, 776 F.2d 706, 714 n. 15 (7th Cir. 1985); *Quad Constr., Inc. v. Wm. A. Smith Contracting Co.*, 534 F.2d 1391, 1394 (10th Cir. 1976). Judge (now Justice) Anthony M. Kennedy summed up this point as follows:

> "A rule for construing contracts against the author is not an alternative to construing it as the parties intended. It is to be applied after the court has inquired into the intent of the parties, and then only if its meaning remains uncertain."

Board of Trade of San Francisco v. Swiss Credit Bank, 597 F.2d 146, 149 (9th Cir. 1979).

Indeed, under any rule of interpretation, be it federal law, California law, or the law of some other jurisdiction,[1] the Court must apply certain rules of interpretation to ascertain the intent of the parties to a contract *prior* to using a rule of construction, such as the one resolving ambiguity against the drafting party. *See, e.g.*, California Civil Code §§ 1636, 1654. These rules require the Court to construe the contract as a whole, not in isolated parts, so as to give effect to every provision. *See, e.g.*, California Civil Code § 1641. Whenever reasonably possible, meaning must be given to every sentence, clause and word, so as to avoid rendering parts of a policy inoperative. *Holz Rubber Co. v. American Star Ins. Co.*, 14 Cal.3d 45, 533 P.2d 1055, 120 Cal.Rptr. 415 (1975). A construction which would give effect to one sentence of a policy, but completely ignore an entire paragraph dealing with the same subject matter, is *not* required by the rule, espoused by Petitioners, that an insurance policy should be liberally construed in favor of the insured. *Henricks v. Metropolitan Life Ins. Co.*, 7 Cal.2d 619, 631, 61 P.2d 1162 (1936).

The proper application of these rules of contract interpretation, as a matter of the "uniform federal law" which Petitioners seek to invoke, *see* Petition, pp. 18-24, leads to the conclusion that Petitioners have no right to benefits under the Group Policy for expenses incurred by them after termination of coverage.[2]

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[1] It is Respondents' position that if and to the extent state law regulates the plan at issue, the law of Illinois, not California, applies. However, for the sake of convenience and to avoid burdening the Court with a discourse on this issue, Respondents refer to California law in this section and in section III, *infra*, because that is the law relied on by Petitioners.

[2] It is especially important that these rules be applied in determining whether medical expense benefits "vest" under employee welfare

(continued)

Indeed, the terms of the Group Policy are not even ambiguous under the very case relied on by Petitioners for this proposition, *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, ___ U.S. ___, 111 S.Ct. 581, 112 L.Ed.2d 587 (1990). Even the *Kunin* court recognized that the rule of *contra proferentem* is applied only "if after applying the normal principles of contractual construction, 'the insurance contract is fairly susceptible of two different interpretations . . .' " *Id.* at 539 (citation omitted). Moreover, the *Kunin* court itself proceeded to analyze the entire policy at issue in that case, not just an isolated phrase or phrases, *id.* at 541, as Petitioners would have this Court do here.

In their attempt to somehow, someway, obtain a benefit for which they did not bargain and which Congress refused to grant, Petitioners ignore this Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that in construing the terms of the policy, the Court must seek out the intent of the trustor. The Court should not, as Petitioners urge it to do, construe the policy in an effort to find ambiguities where none exist and to construe them against the drafter. The Court may not prefer one party's interpretation over that of another.

Accordingly, the Court need not reach the second question, which is not properly presented by this case.

(fn. continued)
benefit plans. It would be anomalous to utilize state common law rules of construction to bring in, via the "backdoor," a mandated vesting requirement which Congress itself rejected. The Court should not utilize preempted state law rules to rewrite ERISA.

III.

THE THIRD QUESTION DOES NOT PRESENT A QUESTION OF GENERAL IMPORTANCE

The third question presented by the Petition is whether the California Court of Appeal's interpretation of a particular insurance policy in the case of *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal. Rptr. 781 (1985), is "saved" from preemption by ERISA's "saving" clause, 29 U.S.C. § 1144(b)(2)(A), as a "law of any State which regulates insurance." Like the first two questions presented by the Petition, this question too does not present an issue of general importance to warrant review by the Court under Supreme Court Rule 10.1(c).

A. The Fields Decision Is Not "Saved" From Preemption.

ERISA provides that it preempts state law relating to employee benefit plans. 29 U.S.C. § 1144(a). State law which "regulates insurance," however, is "saved" from preemption by virtue of the "saving" clause. 29 U.S.C. § 1144(b)(2)(A). In determining whether state law is "saved" from preemption, this Court has adopted the three part test developed under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011, *et seq.* for interpreting the phrase "business of insurance." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743-47 (1985). Under the three part test, a practice falls within the "business of insurance" for purposes of the McCarran-Ferguson Act, and, consequently, for the purpose of

determining whether it is saved from preemption under ERISA's "saving" clause, if (1) the practice has the effect of transferring or spreading a policyholder's risk; (2) the practice is an integral part of the policy relationship between the insurer and the insured; and, (3) the practice is limited to entities within the insurance industry. *Pilot Life Ins. Co. v. Dedeaux, supra*, 481 U.S. at 48-49. Here, the three-part test is not met.

The "practice" at issue, the *Fields* decision, is but a rule of interpretation enunciated by a single court. Indeed, as the District Court noted in granting Allstate and Old Kent Bank's motion for summary judgment, *Fields* is not even followed or "universally accepted" in California. [CR 80, pp. 12-13, ¶ 25.] The *Fields* decision is not a law that "require[s] an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance" and, therefore, subject to the "saving" clause. *Metropolitan Life Ins. Co. v. Massachusetts, supra*, 471 U.S. at 728. Rather, it is a common-law rule of interpretation of a particular contract in the particular circumstances of that particular case.

The "*Fields* rule" does not effect the spread of risk of loss. As the Ninth Circuit, applying this Court's decision in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), noted in *Hahn v. Oregon Physicians Service*, 689 F.2d 840, 843 (9th Cir. 1982), the "business of insurance" only involves an insurer's underwriting and risk spreading functions. Similarly, in *Addrisi v. Equitable Life Assur. Soc.*, 503 F.2d 725, 728 (9th Cir. 1974), the Court noted that the McCarran-Ferguson test focuses on the relationship between an insurance company and its policyholders. And, in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), this Court emphasized that "[t]he transfer of risk from

insured to insurer is effected by means of the contract between the parties — the insurance policy — and that transfer is complete at the time the contract is entered. . . . the insurance policy defines the scope of risk assumed by the insurer from the insured."

Judicial decisions, such as *Fields*, which merely apply state law principles of contract construction, do not effect the transfer of risk by means of the insurance policy. *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990), *cert. denied*, ___ U.S. ___, 111 S.Ct. 2872, 115 L.Ed.2d 1038 (1991); *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426, 429 (6th Cir. 1989). Rather, they rely on *ad hoc*, post-contract analyses to construct a right to benefits not contemplated by the insurer and not underwritten into the premium. It is precisely this type of *ad hoc*, case by case, post-contract type of interpretation that Congress, by enacting ERISA, intended to avoid by enacting a broad preemption clause of "unparalleled breadth" in order to secure uniformity in employee benefit plans and to avoid the uncertainty of a host of conflicting and contradictory judicial interpretations. *See Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *cert. denied*, 477 U.S. 903, *and aff'd*, 477 U.S. 901 (1986); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223, 227 (E.D. Va. 1988).

As the Ninth Circuit noted in *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1440 (9th Cir. 1990):

> "In *Kanne* [*v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, ___ U.S. ___, (1989)], we held that state laws of insurance policy interpretation do not qualify for the saving clause exception

> and are preempted. If we were to preserve 50 different state laws of insurance policy interpretation as federal common law, we would in effect add an item to the saving clause which we have already said that Congress did not mean to include."

B. Even Assuming, For The Sake Of Argument, That The Fields Decision Is "Saved" From Preemption, It Does Not Reflect California Law On the "Vesting" Issue And Its Holding Is Inapposite.

Even if the *Fields* decision is saved from preemption, the very California law which Petitioners seek to incorporate does *not* require an individual's benefits to "vest" upon the termination of group coverage. Rather, California Insurance Code section 10128.2 expressly negates the existence of plaintiffs' alleged "vested rights."

Section 10128.2, entitled "Extension of benefits; discontinuance of policy," provides a 12 month extension of benefits period for employees or dependents who become totally disabled while insured under the policy and who continue to be totally disabled upon the termination of the policy.

In addition, California Insurance Code section 12692 provides a 90 day extension of benefits period in certain circumstances where the section 10128.2 continuance is not applicable.

Thus, California law expressly defines the post-termination benefits that an insurance company must make available to individuals when their group coverage terminates.

The decision in *Fields v. Blue Shield of California*, 163 Cal.App.3d 570, 209 Cal.Rptr. 781 (1985), upon which Petitioners rely in this regard, does not alter this conclusion. The holding in *Fields* was premised on an "ambiguous" modification of the policy at issue in that case, and is not applicable here. Moreover, *Fields* did not deal with the issue of post-termination benefits, nor did it involve any statutory provisions governing the benefits sought, as does this case.

CONCLUSION

The Petition for Writ of Certiorari in this case presents questions which are of limited significance because they were resolved against Petitioners by both courts below based upon the particular and highly unique facts of the case. When these facts are analyzed, it is clear that the terms of the policy itself, statutory law and decisional law simply do not provide Petitioners with the right to the vested benefits which they seek.

The Petition is nothing more than a last-gasp effort by Petitioners to have this Court step in, rewrite the policy, and do what both Congress and the California legislature have refused to do in terms of requiring that employee welfare benefits be "vested." The Petition, therefore, should be denied.

DATED: November 12, 1992.

Respectfully submitted,

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APPENDIX A

STATUTES, REGULATIONS AND RULES

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

(1) the terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(2)(A) Except as provided in subparagraph (B), the terms "employee pension benefit plan" and "pension plan" mean any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that by its express terms or as a result of surrounding circumstances such plan, fund, or program--

(i) provides retirement income to employees, or

(ii) results in a deferral of income by employees for periods extending to the termination of covered employment or beyond,

regardless of the method of calculating the contributions made to the plan, the method of calculating benefits under the plan or the method of distributing benefits from the plan. . . .

29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not extempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities . . . .

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State . . . .

California Insurance Code § 10128.2. Extension of benefits; discontinuance of policy

Every policy containing a life insurance benefit shall contain a reasonable extension of such benefit upon discontinuance of the policy with respect to employees who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. Every policy containing a loss of time benefit, or a hospital, medical, or surgical expense benefit shall contain a reasonable extension of such benefits upon discontinuance of the policy with respect to employees or dependents who become totally disabled while insured under the policy on or after the date this article becomes applicable to such policy and who continue to be totally disabled at the date of discontinuance of the policy. . . .

(d) Every policy providing hospital, medical or surgical benefits on an expense-incurred or service basis shall be deemed to include a reasonable extension of such benefits upon discontinuance of the policy if it provides benefits for covered expenses directly relating to the condition causing total disability existing at the time premium payments for the employee or dependent cease and incurred during a period of not less than 12 months thereafter, which period shall not be interrupted by discontinuance of the policy.

That extension of benefits may be terminated at such time as the employee or dependent is no longer totally disabled or at such time as a succeeding carrier may elect to provide replacement coverage to that employee or dependent without limitation as to the disabling condition.

(e) The benefits payable during any extension of benefits may be subject to all limitations or restrictions contained in the policy.

California Insurance Code § 12692. Continuation benefit coverage; duration; eligible dependents; conditions of availability of coverage

On and after January 1, 1985, every insurer and nonprofit hospital service plan issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer to group policyholders a continuation benefit which if selected, shall have a duration of at least 90 days and which shall be offered consecutively to any federal requirement for continuation benefits. The terms and conditions shall include continuation benefit coverage for widows, widowers, divorced or legally separated spouses, spouses of covered employees becoming entitled to benefits under Title XVIII of the Social Security Act, and their dependents, including dependent children who cease to be dependent children under the plan, who were covered by the group contract on the date of termination of coverage. However, any existing provisions of law regarding termination of a dependent child status shall not be affected by this section.

The continuation of coverage shall be available only under the following conditions:

(a) Those eligible remain within the State of California, although the departure of a dependent child to another state shall not invalidate the continuation provisions for any other family members.

(b) Those eligible do not marry or remarry, although the marriage of any dependent child shall not invalidate the continuation provisions for other family members.

(c) Those eligible are not eligible for any comparable state, federal, or private group medical plan, although the eligibility of any dependent child shall not

invalidate the continuation provisions for other family members.

(d) Those eligible do not find employment with an employer that has a group plan of its own, even if the plan is less substantive, although the entry into such an employee plan by a dependent child shall not invalidate the continuation provisions for other family members.

(e) The group policy is not terminated or the employer's participation in the group policy is not terminated.

(f) Those eligible do not knowingly furnish incorrect information or otherwise improperly obtain the benefits of the plan.

(g) The continuing individual shall pay the premium amount in the manner specified in the group policy for both his or her share of the premium and the group policyholder's share, if any.

(h) Eligible persons under this section shall be notified in the same manner required for conversion notification pursuant to Section 12689. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.

Supreme Court Rule 10. Considerations Governing Review On Writ Of Certiorari

.1. A review on writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of certiorari will be granted only when there are special and important reasons therefor. The following, while neither controlling nor fully measuring the Court's discretion, indicate the character of reasons that will be considered:

. . .

(c) When a state court or a United States court of appeals has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way that conflicts with applicable decisions of this Court.